

Fax Completed enrollment form to:

Individual Enrollment 1-866-935-4916



Application for Customers Rewards Program:

Member Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home or Cell Phone Number: _____ E-Mail Address: _____

Social Security Number: _____ Date of Birth: _____

Dependent Information:

	<u>First Name</u>	<u>Last Name</u>	<u>Sex</u>	<u>Date of Birth</u>	<u>Soc. Sec. #</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

All New Members must Read and Sign Below: I understand that Customers Rewards program benefits are not insurance, they are professional discount and savings programs. I understand that in order to receive the program savings I must access the contracted networks and pay the provider at time of service. I agree to abide by these terms and conditions. I also understand that Medical Benefits Network and their sales associates are not responsible for the outcome of the care received or the cost of this care.

Applicant Signature: _____ Print Name: _____ Date: _____

Agent Name: _____ Date: _____

Membership Cost: _____ Effective Date: (1st of the month) _____ Drafted Annually on Renewal Month **

Credit Card Payments:

Visa Master Card #: _____ EXP Date: _____

Name on Card: _____ Check if same name and address above.

Billing Address: _____ (On back of card) 3 digit security code _____

City: _____ State: _____ Zip _____

Signature X: _____ Date: _____ Amount: _____

Program Cost: \$40.00 (Check or Cash)

10% Discount for (Visa & Master card)

Program Cost: \$36.00

IMPORTANT NOTICE:

****Cancellation requests are to be submitted to us in writing 30 days prior to requested cancellation date. Cancellations are the 1st of the month.**